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Medical Malpractice in the Birthplace: Resolving the Physician-Patient Conflict through Informed Consent, Standard of Care, and Assumption of Risk

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Medical Malpractice in the Birthplace: Resolving the Physician- Patient Conflict Through Informed Consent, Standard of Care, and Assumption of Risk

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I. INTRODUCTION—OBSTETRICS UNDER ATTACK

A widely acknowledged crisis exists today throughout the field of medical practice. In recent years many physicians have been con-

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fronted with malpractice insurance premiums that in some cases have increased by as much as one-hundred percent or more yearly.¹ Annual premiums of several thousand dollars are common, and some physicians are paying more than \$100,000 annually for insurance.² Others prefer the risk of "going bare" to paying such exorbitant rates.³ Contributing to these astronomical insurance rates is the increase in malpractice litigation with resulting awards to successful plaintiffs.

Exacerbating the problem is a frequently adopted approach to malpractice suit avoidance, the ordering of more tests and procedures than the physician believes is necessary or beneficial. While there are other reasons for the overuse of tests, this is done largely in an attempt to better assure a correct diagnosis so as to minimize the possibility of a bad medical outcome or to provide a strong defense to a malpractice claim.⁴ Many observers believe that this practice is one of the main reasons for today's skyrocketing health care costs.⁵

In response to intense pressure to adhere to prevailing standards of care, and in response to the recent dramatic increases in malpractice litigation and insurance premium rates, obstetricians in the childbirth setting frequently engage in this kind of "defensive medicine."⁶ This

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1. Sullivan, *Doctors and Insurers*, N.Y. Times, Feb. 28, 1985, at B4, col. 5; Katz, *State's Doctors Begin Cutting Back Services to Reduce Legal Costs*, Det. Free Press, Aug. 4, 1985, at 14A, col. 5; McCaughan, *Doctor's Fees Soar for Fewer Services*, Lansing State J., July 7, 1985, at 1E, col. 1. The average increase for surveyed Michigan obstetricians in 1985 was 70%. M. Block, *Professional Liability Insurance and Obstetrical Practice* 10 (1985) (survey commissioned by the Mich. State Medical Soc'y and the Mich. Section of Am. College of Obstetricians and Gynecologists).
 2. Kleinfield, *The Malpractice Crunch at St. Paul*, N.Y. Times, Feb. 24, 1985, at 4F, col. 3.
 3. Omicinski, *High Premiums Forcing Doctors to Drop Malpractice Insurance*, Lansing State J., July 7, 1985, at 6E, col. 3.
 4. Altschule, *Bad Law, Bad Medicine*, 3 AM. J.L. & MED. 295, 296 (1977) (discussing how doctors order such excessive tests in "self-defense"); Det. Free Press, Aug. 4, 1985, at 14A, col. 5; Blakeslee, *Doctors Debate Surgery's Place in the Maternity Ward*, N.Y. Times, Mar. 24, 1985, at E24, col. 1 (discussing doctors' use of cesarean sections to avoid law suits). But see Bernzweig, *Defensive Medicine*, REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE, U.S. DEP'T OF HEALTH, EDUC. & WELFARE app. (1973) [hereinafter cited as HEW REPORT].
 5. See, e.g., N.Y. Times, Feb. 4, 1985, at A18, col. 1 ("defensive medicine may inflate medical costs by 30 percent"); Altschule, *supra* note 4, at 296; Nichols, *Doctors Say Suits Revise Medical Practice*, Lansing State J., Nov. 11, 1985, at 8A, col. 2; J. LIEBERMAN, *THE LITIGIOUS SOCIETY* 86 (1981). See also MEDICAL TECHNOLOGY: THE CULPRIT BEHIND HEALTH CARE COSTS? (S. Altman & R. Blendon eds. 1979).
 6. Malcolm, *Fear of Malpractice Suits Spurring Some Doctors to Leave Obstetrics*, N.Y. Times, Feb. 12, 1985, at A1, col. 1 (discussing how doctors order more tests than medically necessary because they are legally necessary). Also, obstetricians cite the threat of malpractice suits as the reason for the increase in the rate of cesarean deliveries. H. MARIESKIND, *AN EVALUATION OF CAESAREAN SECTION IN THE UNITED STATES* 82 (1979); Block, *supra* note 1, at 8.

results in heavy reliance on obstetrical "high technology."⁷ In addition to increasing health care costs, use of this technology has been found to result in negative birth experiences ranging from an emotionally unsatisfying birth to severe iatrogenic⁸ and nosocomial⁹ injuries to the mother or infant or both.¹⁰

Few medical specialties have felt the impact of the malpractice hysteria more than obstetrics.¹¹ Constrained by a high technology standard of care on the one hand and the law on the other, obstetricians believe their alternatives are few. The problem has become so severe for this group that more and more practitioners who either specialize in obstetrics and gynecology or family or general practice have eliminated¹² or are contemplating the elimination of¹³ the obstetrical aspect of their practice. These physicians feel that the income and other rewards they realize are insufficient in light of the costs involved, and they fear being sued for malpractice.¹⁴ This could mean that in the future there will be insufficient numbers of obstetricians to meet consumer demand for obstetrical services.¹⁵

Physicians' fear of malpractice suits, combined with increasing use of high technology obstetrical procedures, has resulted in a situation

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7. In this Article the terms "high technology," "obstetrical high technology," and "obstetrical intervention" refer to physicians' intervention in the childbirth process. Physician intervention includes use of the following: amniocentesis, ultrasound, electronic fetal monitoring, amniotomy, labor-inducing hormone injections, pain-killing drugs, forceps delivery, shaving the perineum, cesarean section, and episiotomy.
 8. An iatrogenic injury is one resulting from treatment by a physician. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 647 (26th ed. 1981).
 9. Nosocomial injuries or diseases are those that originate in a hospital. *Id.* at 902.
 10. For example, complications of cesarean deliveries include the following: future cesarean deliveries, psychological distress, gas, infection (intrauterine cystitis, peritonitis, abscess, gangrene, generalized sepsis), hemorrhage, adhesions, fistula, sinuses, wound dehiscence, subsequent uterine rupture, injury to adjacent organs (e.g., uterus, bladder, bowel), side effects of blood transfusion (e.g. hepatitis), thromboemboli, thrombophlebitis, aspiration pneumonia, anesthesia accidents, cardiac arrest, cerebral vascular accidents, and death. H. MARIESKIND, *supra* note 6, at 43-45. Possible fetal injuries resulting from the use of electronic fetal monitoring include potential dangers of early amniotomy (including cord prolapse, infection, and increased stress due to elimination of amniotic fluid cushion), trauma, infection, and hemorrhage. WILLIAMS OBSTETRICS 359-60 (J. Pritchard & P. MacDonald, eds. 16th ed. 1980).
 11. The medical specialists currently paying the highest rates are obstetricians, surgeons, and anesthesiologists, BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 105 (1985) [hereinafter cited as STATISTICAL ABSTRACT]; McCaughan, *supra* note 1, at 1E, col. 1; Malcolm, *supra* note 6, at A1. Block, *supra* note 1, at 10, cites average 1984 premium rate for Michigan obstetricians at \$15,400, rising to \$26,200 in 1985.
 12. See, e.g., Malcolm, *supra* note 6, at A1. See also Block, *supra* note 1, at 5-7.
 13. Block, *supra* note 1, at 5-7.
 14. *Id.* at 16; State News, (East Lansing, Mich.), July 29, 1985, at 3, col. 5.
 15. Block, *supra* note 1, at 14; State News, *supra* note 14, at 3, col. 5.

where birthing women have almost no medical decisionmaking authority regarding their labor and delivery. Pregnant and birthing women are virtually coerced to submit to constantly changing obstetrical standards of care that are increasingly based on high technology whose efficacy has not been substantiated by scientific testing. Birthing women who desire the safety of physician-attended hospital births, as most women and their families do,¹⁶ find themselves faced with few alternatives.

This Article investigates some of the causes of the current malpractice crisis in medicine in general and obstetrics in particular. It suggests steps that can be taken by courts and legislatures to resolve the underlying problems that have given rise to a state of affairs that is unsatisfactory both to many pregnant women, because it excludes them from decisionmaking and leads to unnecessary injuries, and to their physicians, because of increasing numbers of malpractice claims.

II. BACKGROUND—THE DEVELOPMENT AND SCOPE OF THE PROBLEM

At the same time that obstetricians have faced greater numbers of malpractice suits,¹⁷ the standard of care against which their actions are measured has changed dramatically. When physicians first began to attend births with regularity in the 1800s, there was relatively little they could do that proved beneficial to the mother or child.¹⁸ Ironically, in the early days of obstetrical practice it appears that physicians' care and hospital settings frequently led to poor results.¹⁹

Today's obstetrician, in contrast, has a wide array of techniques and equipment available for use in pregnancy and delivery that, according to the medical community, provide great benefits.²⁰ Many of these techniques, procedures, and equipment were developed primarily to respond to women and babies in a *high-risk* birth situation;²¹ however, they have become the standard of care and are routinely used in the *normal* birth setting.²² The latter practice has come under

16. Y. BRACKBILL, J. RICE & D. YOUNG, BIRTH TRAP 59 (1984); Dallek, *Labor and Delivery as a Medical Emergency*, 10 CLEARINGHOUSE REV. 947, 949 (1977).

17. STATISTICAL ABSTRACT, *supra* note 11, at 105.

18. BIRTH TRAP, *supra* note 16, at 1. Women increasingly sought physician-attended births after 1840, however, because physicians had the means to relieve the pain of delivery, and because it became the fashion to do so. R. WERTZ & D. WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA 109-19 (1977).

19. R. WERTZ & D. WERTZ, *supra* note 18, at 119-28.

20. WILLIAMS OBSTETRICS, *supra* note 10.

21. *Id.* at 329-68; BIRTH TRAP, *supra* note 16, at 44.

22. WILLIAMS OBSTETRICS, *supra* note 10, at 329-68. This development is the result of a lack of obstetrical training in normal birth. H. MARIESKIND, *supra* note 6, at 5-7. This is also caused by physicians classifying all women as at risk or high risk. B. KATZ ROTHMAN, GIVING BIRTH: ALTERNATIVES IN CHILDBIRTH 131-39 (1982).

increasing scrutiny and criticism.²³

In general, analysts criticize the failure to substantiate the effectiveness of any of these interventions prior to their incorporation into obstetrical protocols.²⁴ Standard medical textbooks instruct students that these procedures are appropriate,²⁵ yet investigation reveals that there have been few scientific studies to establish their benefits or document their risks.²⁶ More and more scholars, physicians, and birthing women find this unacceptable.²⁷

The use of obstetrical high technology raises additional concerns. A growing number of researchers contend that routine use of these procedures is unnecessary²⁸ and, as a result, poses needless risks to mother and infant.²⁹ In fact, medical intervention in the birth process may end in serious physical iatrogenic and nosocomial injuries to both the mother and the baby, including death and permanent disability.³⁰

Another type of injury that may result from obstetrical intervention in childbirth is interference in mother-baby bonding. In studies published in the 1970s and 1980s, researchers documented the critical nature of this first phase in the development of the parent-child relationship.³¹ Mothers and babies who are drugged and mothers recovering from the pain and depression of a surgical delivery have much greater difficulty bonding than those who experience immediate, close, and prolonged contact following parturition.³² Interference with bonding may lead to serious and sometimes lifelong problems.³³

Risks of medical intervention in childbirth also include negative emotional reactions. For example, severe depression in women after

23. OBSTETRICAL INTERVENTION AND TECHNOLOGY IN THE 1980S (D. Young ed. 1983) [hereinafter cited as OBSTETRICAL INTERVENTION]; Adams, *The Use of Obstetrical Procedures in the Care of Low-risk Women*, 8 WOMAN & HEALTH 25 (1983); BIRTH TRAP, *supra* note 16; Brody & Thompson, *The Maximin Strategy in Modern Obstetrics*, 12 J. FAM. PRAC. 977, 983 (1981); Chalmers & Richards, *Intervention and Causal Inference in Obstetric Practice*, in BENEFITS AND HAZARDS OF THE NEW OBSTETRICS 34 (T. Chard & M. Richards eds. 1977); H. MARIESKIND, *supra* note 6, at 192-96.

24. *See supra* sources at note 23.

25. WILLIAMS OBSTETRICS, *supra* note 10.

26. *See supra* sources at note 23.

27. S. ARMS, IMMACULATE DECEPTION (1975); BIRTH TRAP, *supra* note 16.

28. *See supra* sources at note 23.

29. *See supra* sources at note 23.

30. *See supra* note 10 for a discussion of possible serious injuries resulting from various medical interventions.

31. M. KLAUS & J. KENNEL, PARENT-INFANT BONDING (2d ed. 1982).

32. *Id.* at 33-34.

33. *Id.* at 47-48; Rice, *Maternal Infant Bonding: The Profound Long-Term Benefits of Immediate Continuous Skin and Eye Contact At Birth*, in 2 TWENTY-FIRST CENTURY OBSTETRICS NOW, 373 (D. Stewart & L. Stewart, eds. 1977).

cesarean deliveries has been amply documented.³⁴ Use of cesarean section is acknowledged to be a valuable procedure when it is necessary, but currently soaring rates of surgical deliveries³⁵ have led a number of observers to question how many cesarean deliveries are unnecessary.³⁶ Hence, a large percentage of cesarean section patients may be suffering unnecessarily an often devastating emotional injury, in addition to the risks of major abdominal surgery.

Heightened concern about rising health care costs and a desire to "contain" those costs are leading to greater scrutiny of the choices health care providers make in treatment decisions. Health care expenditures have increased by 300% since 1950³⁷ and accounted for 10.8% of the Gross National Product in 1983.³⁸ Even the untrained observer can readily see that use of additional tests and procedures increases the cost of health care, and that, as a result, the least costly childbirth is one in which no medical interventions are used. As each procedure is introduced, costs begin to climb.³⁹ Apart from other potential benefits, a reduction of unnecessary medical intervention in childbirth should lower health care costs.

Largely due to the use of obstetrical high technology and medical school training (which focuses on pathology rather than wellness),⁴⁰ it can be seen that the natural physiological childbirth process has become regarded as a disease condition⁴¹ and the mother and baby are seen as patients in need of medical treatment.⁴² Instead of a woman giving birth in proximity to medical attendants in the event their serv-

34. BIRTH TRAP, *supra* note 16, at 26; Affonso & Stichler, *Exploratory Study of Women's Reaction to Having a Cesarean Birth*, 5 BIRTH & FAM. J. 88 (1978).

35. Marieskind, *Cesarean Section*, in OBSTETRICAL INTERVENTION, *supra* note 23, at 183; Placek, Taffel & Moien, *Cesarean Section Delivery Rates: United States, 1981*, 73 AM. J. PUB. HEALTH 861 (1983).

36. BIRTH TRAP, *supra* note 16, at 22-31; Marieskind, *supra* note 35, at 188-92.

37. J. GUINHER, THE MALPRACTITIONERS 121 (1978).

38. STATISTICAL ABSTRACT, *supra* note 11, at 96.

39. For example, an "uncomplicated" hospital birth might cost \$2,239 while one involving a relatively uncomplicated cesarean section delivery might run \$7,500. BIRTH TRAP, *supra* note 16, at 4.

40. For example, "[the emphasis on pathology in this edition] has been continued because more than a mere acquaintance with pathology is an absolute requirement for the superior practice of gynecology." NOVAK'S TEXTBOOK OF GYNECOLOGY vii (H. Jones & G. Jones 10th ed. 1981). See also WILLIAMS OBSTETRICS, *supra* note 10, which devotes approximately 600 pages to complications of pregnancy, 300 to anatomy and 45 to prenatal care and family planning, and in which normal birth is presented as requiring numerous medical interventions. *Id.* at 405-34.

41. BIRTH TRAP, *supra* note 16, at 31, 47; B. KATZ ROTHMAN, *supra* note 22, at 37; S. ARMS, *supra* note 27, at 64; Thacker & Banta, *Benefits and Risks of Episiotomies*, in OBSTETRICAL INTERVENTION, *supra* note 23, at 164.

42. See also B. JORDAN, BIRTH IN FOUR CULTURES 35 (1983) (the inclusion of pregnancy and childbirth in the medical realm has transformed the pregnant woman into a "patient"); WILLIAMS OBSTETRICS, *supra* note 10, at 8.

ices are needed, a "modern" birthing woman turns herself over to health care providers who deliver the baby for her following obstetrical protocols based on a high technology standard of care.⁴³

In this setting, at a time of tremendous vulnerability, the birthing woman has little control over the sequence and progression of events leading to the birth of her child.⁴⁴ She is made to feel guilty if she does not docilely and unquestioningly accept each succeeding step chosen by the physician.⁴⁵ Thus, the pregnant woman who desires the safety of a hospital birth finds herself with little decisionmaking authority. This poses a dilemma for American women who have a strong belief in the safety of the hospital.⁴⁶ A laboring woman may go to the hospital and do as she is told or she may make all of the decisions herself and take what is perceived as the unacceptably high risk of home birth.⁴⁷

A growing number of women seek to change this situation and to make decisions regarding the births of their children.⁴⁸ These would-be decisionmakers have encountered a formidable obstacle in the path to shared decisionmaking—physicians' intransigence. Most physicians are extremely reluctant to relinquish control and highly resistant to any changes in the power alignment of the typical doctor-patient relationship as it exists today.⁴⁹ Physicians themselves express a number of reasons for this, and other observers also have been able to provide insight.

Jay Katz, a physician-lawyer who has thoroughly investigated shared decisionmaking through analysis of the informed consent doctrine,⁵⁰ points out that physicians historically have maintained silence on treatment and diagnosis issues because of their training.⁵¹ Summarizing Katz's discussion, the bases for this practice rest in the beliefs that these disclosures are "inimical to good patient care;"⁵² if the truth were told, patients would lose faith in the physician;⁵³ the truth would be injurious to the patient;⁵⁴ patients owe a duty of obedience to the

43. BIRTH TRAP, *supra* note 16, at 1-23; WILLIAMS OBSTETRICS, *supra* note 10, at 405-34.

44. B. KATZ ROTHMAN, *supra* note 22, at 178.

45. See generally Morrow, *Women's Health Care and Informed Consent: Who Should Decide What Is Best for Woman—Patients or Doctors?*, 9 GOLDEN GATE L. REV. 553 (1979); B. KATZ ROTHMAN, *supra* note 22, at 175.

46. BIRTH TRAP, *supra* note 16, at 58.

47. B. KATZ ROTHMAN, *supra* note 22, at 41-42; Dallek, *supra* note 16, at 948.

48. BIRTH TRAP, *supra* note 16, at 47, 56; B. KATZ ROTHMAN, *supra* note 22, at 109.

49. J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 27 (1984).

50. This doctrine is discussed *infra* text accompanying notes 111, 151-97.

51. J. KATZ, *supra* note 49, at 3.

52. *Id.* at 2.

53. *Id.* at 11 (discussing a work of Samuel de Sorbiere).

54. *Id.* at 19 (quoting T. PERCIVAL, *MEDICAL ETHICS* (1803)).

physician;⁵⁵ and conversation is reserved for convincing patients of the correctness of the physician's chosen mode of action.⁵⁶ Katz stresses the failure of the physician community to consider the liberty issue implicit in informed consent.⁵⁷ Instead, the physicians' model of good care is a paternalistic one predicated on the patient placing herself in the "custody" of the physician.⁵⁸ Full disclosure and shared decision-making, then, are "alien to medical thinking and practice."⁵⁹

Today, this tradition of silence continues through the training of obstetricians. In general, physicians are taught that, due to their greater knowledge,⁶⁰ they should be in control of medical decision-making.⁶¹ In particular, they develop an especially paternalistic attitude about their female patients⁶² that precludes the possibility of shared decisionmaking. Furthermore, physicians are trained in medical school to view childbirth as a disease process⁶³ that requires their expertise and control instead of a natural event that in most cases can proceed without medical intervention.⁶⁴

Many physicians cite the fear of malpractice suits as a critical factor in their insistence on exclusive decisionmaking power and their reliance on high technology;⁶⁵ thus, they keep abreast of the latest court rulings and make treatment decisions consistent with those rulings.⁶⁶ These court-influenced medical decisions may or may not be in the best interests of the patient, but physicians feel themselves increasingly under siege⁶⁷ and have resorted to this type of decisionmaking in order to protect themselves from adverse rulings in the event they are sued.⁶⁸ Malpractice suits are unquestionably a major problem for today's physicians, and in order to develop strategies to alleviate this problem, one must consider its roots and causes.

55. J. KATZ, *supra* note 49, at 1, 21 (quoting the American Medical Association's first code of ethics).

56. *Id.* at 5-6 (discussing Plato's views on treatment of "the free and rich" patients).

57. *Id.* at 2.

58. *Id.*

59. *Id.* at 1.

60. *Id.* at 26-27 (quoting the opinion of a group of senior surgeons).

61. *Id.* at 1-30; see generally Morrow, *supra* note 45, at 556; 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 129 (1982) [hereinafter cited as MAKING HEALTH CARE DECISIONS].

62. Morrow, *supra* note 45, at 556-57.

63. B. KATZ ROTHMAN, *supra* note 22, at 131-39.

64. R. BRADLEY, HUSBAND-COACHED CHILDBIRTH 196 (3d ed. 1981).

65. Interviews by author of Lansing obstetrician Dr. Jairam Rajan (July 17 & Sept. 28, 1984). See also Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 965 (citing negative defensive medicine as a possible adverse impact on malpractice litigation); Nichols, *supra* note 5 at 8A, col. 2.

66. See *supra* sources at note 65.

67. See *supra* sources at note 65.

68. See *supra* sources at note 65.

Poor medical outcome is the leading cause of medical malpractice litigation,⁶⁹ and, therefore, is another reason physicians wish to retain exclusive decisionmaking authority. Equipped with expertise, physicians believe that they are in the best position to make choices that will result in an optimal outcome.⁷⁰ Satisfied customers generally do not complain, even if an unorthodox approach or a less than optimal procedure was used. Results are what count. Those who are unhappy about or injured by a poor outcome do complain: they sue. Physicians apparently believe that they can minimize the risk of a poor outcome and a resultant lawsuit by exerting full control over medical treatment decisions.

When it comes time for an injured patient to decide whether to sue, the effect of a poor medical outcome is aggravated by the frequent absence of a personal relationship with the attending physician. The literature discussing the doctor-patient relationship has been written by scholars from a number of disciplines including law, philosophy, medicine, journalism, anthropology, and sociology. Observers with varied expertise agree on what they perceive to be a key to the increase in malpractice litigation: the very poor or nonexistent relationship between doctor and patient.⁷¹ In the past, many patients viewed the doctor as a trusted confidante, virtually a member of the family.⁷² Even if his judgment or procedure was imperfect, his failings could be forgiven and forgotten; his patients and their families were convinced that the doctor had done the best he could and that he genuinely cared about them.⁷³ This type of relationship appears to be the exception today.⁷⁴

One can mark the change in the doctor-patient relationship at about the time the rate of malpractice litigation began its climb in the 1950s. Today's physician-patient relationship is marked not by friendship and the laying on of hands, but by its brevity. In order to make

69. J. GUINER, *supra* note 37, at 46.

70. J. KATZ, *supra* note 49, at 26-27 (quoting the opinion of a group of senior surgeons).

71. J. GUINER, *supra* note 37, at 115-16; D. ENOS & P. SULTAN, *THE SOCIOLOGY OF HEALTH CARE* 354-55 (1977); Annas, *Avoiding Malpractice Through the Use of Informed Consent*, *CURRENT PROBS. PEDIATRICS*, Nov. 1976, at 2, 11-17; Morrow, *supra* note 45, at 570-71; Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice*, *HEW REPORT, supra* note 4, at app. 84; Peterson, *Consumers' Knowledge and Attitudes Toward Medical Malpractice*, *HEW REPORT, supra* note 4, at app. 666-67. Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 *BROOKLYN L. REV.* 241, 248-49 (1978). For a review of the empirical studies of doctor-patient interactions, see *Physician-Patient Relationships* in *SOCIAL CONTEXTS OF HEALTH, ILLNESS AND PATIENT CARE* 104, 109 (E. Mishler ed. 1981).

72. D. ENOS & P. SULTAN, *supra* note 71, at 63-64.

73. *Id.*

74. *Id.* See also J. LIEBERMAN, *supra* note 5, at 90-91.

their medical practices efficient and profitable, to treat as many patients as possible in a given period of time, physicians increasingly rely on assistants to complete all tasks except those requiring physician execution.⁷⁵ Ironically, physicians on the front line, who treat patients day by day and whose training is in evaluating symptoms to arrive at a diagnosis, seem not to have grasped this fact nor to have taken steps to "treat" their own problem.

A problem this complex has more than one cause. In addition to the poor quality of the relationship between many physicians and patients, which makes it easier for the patient to sue, the patient often has high and unrealistic expectations about the potential outcome of treatment.⁷⁶ Many patients have developed an expectation of a perfect outcome every time. This is due, on the one hand, to a general societal belief that modern technology can fix anything⁷⁷ and, on the other hand, to the shroud of mystery and superhuman powers in which the medical community prefers to clothe itself.⁷⁸ It appears to be no longer acknowledged or understood that medical science to a large extent remains inexact and groping for answers.⁷⁹ The specialization of medical providers also plays a role in creating high patient expectations. Patients expect a provider with more knowledge and expertise when that provider is a specialist.⁸⁰ It is partially for this reason that specialists in potentially high risk areas such as neurosurgery, orthopedics and obstetrics are subject to greater numbers of malpractice suits.⁸¹

Commentators also point out that civil litigation as a whole is generally at a higher level today and correctly note that medical malpractice is but one area of many which have experienced an exponential rise in suits.⁸² Consumers, it appears, now understand that they have rights on which they may sue. Beginning in the 1960s with the pro-consumer warranties decisions,⁸³ pro-tenant decisions⁸⁴ and Ralph Nader's successful attack on the General Motors Corporation Corvair in

75. G. BALLETT, GETTING STARTED IN PRIVATE PRACTICE 225-28 (1978); H. COTTON, MEDICAL PRACTICE MANAGEMENT 146-47 (1967); J. LAWSON & J. MCCONNELL, STARTING AND MANAGING YOUR PRACTICE 93-94, 100-01 (1983).

76. J. GUINThER, *supra* note 37, at 116; D. ENOS & P. SULTAN, *supra* note 71, at 352-53; Brinkley, *Physicians Have an Image Problem—It's Too Good*, N.Y. Times, Feb. 10, 1985, at E6, col. 3.

77. See also Ubell, *How Today's Surgeons Perform the Impossible*, PARADE MAGAZINE, Nov. 3, 1985, at 4-7.

78. J. KATZ, *supra* note 49, at 26-29, 45.

79. *Id.* at xvii.

80. J. GUINThER, *supra* note 37, at 116.

81. Malcolm, *supra* note 6, at A1, col. 1.

82. For example, the rate of civil litigation (as measured by the number of suits filed in federal district courts) rose 22% from 1980 to 1982. J. LIEBERMAN, *supra* note 5, at 5.

83. See, e.g., *Browne v. Fenestra, Inc.*, 375 Mich. 566, 134 N.W.2d 730 (1965); Vander-

Unsafe At Any Speed,⁸⁵ consumers began to acquire legal rights. Following these pro-consumer court decisions, state legislatures and Congress enacted a series of consumer rights statutes in the 1960s and 1970s, most prominently in the area of consumer fraud,⁸⁶ defective products,⁸⁷ landlord-tenant law⁸⁸ and credit.⁸⁹ The once downtrodden and timid consumer is now able and willing to freely protest perceived mistreatment.

A clear connection exists between the assertion of consumer rights in the marketplace of goods and services and in the marketplace of health care services. Since consumers have been accorded substantial rights in their roles as consumers of goods and services, they appear to be less willing to accept a lack of rights or mistreatment in other areas of their lives. The skepticism they have developed in dealing with defective products, landlords and financial institutions permeates their world view.

With greater rights and more education about those rights,⁹⁰ today's consumers are far more likely to sue when the quality of goods or services is not what they expected or not what they were promised. Apparently, this consumer skepticism also colors the health consumer's perception of medical services and providers.⁹¹ Revelations about potential dangers in birth control pills,⁹² intrauterine devices⁹³

mark v. Ford Motor Co., 61 Cal. 2d 256, 391 P.2d 168, 37 Cal. Rptr. 896 (1964); Henningsen v. Bloomfield Motors, Inc., 32 N.J. 358, 161 A.2d 69 (1960).

84. See, e.g., Javins v. First Nat'l Realty Corp., 428 F.2d 1071 (D.C. Cir.), cert. denied, 400 U.S. 925 (1970); Pines v. Perssion, 14 Wis. 2d 590, 111 N.W.2d 409 (1961).

85. In his book Nader brought attention to the disproportionate number of accidents and serious injuries caused by defective automobile design, especially in the case of the Corvair. R. NADER, *UNSAFE AT ANY SPEED* (2d ed. 1972).

86. See, e.g., Michigan Consumer Protection Act, MICH. COMP. LAWS ANN. §§ 445.901-445.922 (Supp. 1985).

87. Consumer Product Safety Act, 15 U.S.C. §§ 2051-2083 (1982).

88. See, e.g., Michigan statutes prohibiting retaliatory evictions, MICH. COMP. LAWS ANN. § 600.5720 (Supp. 1985); regulating landlord-tenant relationships, MICH. COMP. LAWS ANN. §§ 554.601-554.616 (Supp. 1985); and prohibiting certain lease clauses, MICH. COMP. LAWS ANN. §§ 554.631-554.641 (Supp. 1985).

89. See, e.g., Consumer Credit Protection Act, 15 U.S.C. §§ 1601-1693(r) (1982).

90. J. GUINTEH, *supra* note 37, at 121. It also has been suggested, however, that some patients' lack of education may foster the belief that poor outcomes necessarily imply negligence. Annas, *supra* note 71, at 11.

91. BIRTH TRAP, *supra* note 16, at 115; B. KATZ ROTHMAN, *supra* note 22, at 109.

92. In his preface to a book reviewing much of the contraceptive literature, K. Moghissi acknowledged that studies were being undertaken only *after* many years of use of these products and that these products had been approved for use based on flawed clinical trials. *CONTROVERSIES IN CONTRACEPTION* (K. Moghissi ed. 1979). See also Tietze, *New Estimates of Mortality Associated with Fertility Control*, 9 FAM. PLAN. PERSP. 74 (1977); BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *THE NEW OUR BODIES, OURSELVES* 237-47 (1984).

93. See D. EDELMAN, F. BERGER & L. KEITH, *INTRAUTERINE DEVICES AND THEIR COMPLICATIONS* (1979); *THE NEW OUR BODIES, OURSELVES*, *supra* note 92, at 249-55;

and the use of diethylstilbestrol (DES) to prevent miscarriages,⁹⁴ made several years after thousands of women had used (and been injured by) these products, may have played a significant role in arousing suspicion about other aspects of women's health care⁹⁵—obstetrics, for example. Thus, the dramatic increase in medical malpractice litigation comes as no surprise to those steeped in the law and practice of consumer rights and women's health care.

Physician incompetence is another significant aspect of the medical malpractice crisis.⁹⁶ Although the medical community often believes that very few of the medical malpractice suits filed are justifiably based on malfeasance,⁹⁷ the incompetence of physicians (and other health care providers) has been documented.⁹⁸ The injurious diagnosis made or treatment given by a negligent provider is actionable, and theoretically, the provider may lose his or her license to practice as well.

In practice, however, the medical delicensing system is an abysmal failure.⁹⁹ Only in the most egregious cases is a physician ever taken to task, and even then the most likely result is an admonishment or

Comment, *Physicians' Liability: The State and Insertion of a Dalkon Shield*, 11 CAL. W.L. REV. 347, 347-50 (1975).

94. DES is a synthetic estrogen manufactured by hundreds of drug companies and prescribed by doctors to millions of pregnant women between the years 1947 and 1971. Use of DES by these women has been linked to the subsequent development of cancer in the users' daughters who were exposed to the drug *in utero*. See Comment, *DES and a Proposed Theory of Enterprise Liability*, 46 FORDHAM L. REV. 963, 963-64 (1978). See also THE NEW OUR BODIES, OURSELVES, *supra* note 92, at 496-500.
95. See generally THE NEW OUR BODIES, OURSELVES, *supra* note 92, esp. xiii & xvii. See also Morrow, *supra* note 45, at 554 (discussing how authorities concerned with women's health care urge women to be concerned about decisions made in their behalf because the health care system has erred seriously "in their behalf" in the past).
96. J. GUINThER, *supra* note 37, at 144-52; Katz, *Bad Doctors: License to Err*, Det. Free Press, Apr. 1-8, 1984 (7-part series); Wolfe, Bergman & Silver, *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform* 2-3, a report of Public Citizen Health Research Group (Aug. 27, 1985) (available from Public Citizen Health Research Group, 2000 P. Street, N.W., Suite 708, Washington, D.C. 20036). See generally Brinkley, *Should Doctors Be Given a More Thorough Examination?*, N.Y. Times, Nov. 10, 1985, at 10E, col. 1.
97. See, e.g., Margolik, *Medical Malpractice: The Role of Lawyers*, N.Y. Times, Feb. 21, 1985, at A16, col. 3. See also Barber, *Why So Many Malpractice Suits?*, FEMALE PATIENT, Aug. 1983, at 14-19. Dr. Barber believes that the malpractice crisis has been caused by greedy lawyers. He states: "The conduct or misconduct of malpractice lawyers is an embarrassment to the elite lawyers of integrity." *Id.* at 15.
98. See J. GUINThER, *supra* note 37.
99. *Id.* at 144-47; Katz, *Compromise Is the Rule for Board of Medicine*, Det. Free Press, Apr. 3, 1984, at 13, col. 1; Katz, *Some Watchdogs Have Little Bite*, Det. Free Press, Apr. 6, 1984, at 1A, col. 3; Wolfe, Bergman & Silver, *supra* note 96, at i-ii; Brinkley, *supra* note 96, at 10E, col. 1.

short suspension.¹⁰⁰ Moreover, physicians denied the right to practice in one state may move with ease to another where generally nothing may be done to prevent them from practicing until they commit malpractice in the new state.¹⁰¹ The physicians themselves control these ineffective grievance procedures,¹⁰² and they seem very reluctant to report or take strong action against a colleague.¹⁰³ In addition, weak procedures and the way in which the agency and court system implement them pose significant obstacles to delicensure.¹⁰⁴ As a consequence, the vast majority of incompetent physicians continue to practice.¹⁰⁵

III. ANALYSIS

Historically, medical malpractice as a cause of action grew out of a breach of the contract between physician and patient.¹⁰⁶ Alternatively, an injured patient could make out a case of battery if the physician did not have consent to proceed.¹⁰⁷ The theory of battery is grounded in the right of the individual to be free from unwanted invasions in his or her body.¹⁰⁸ Consequently, a battery can be committed even when the physician uses great skill and care or has not injured the patient.¹⁰⁹

Where skill and care are at issue, the plaintiff's action is in negligence.¹¹⁰ The plaintiff suing in negligence has two main arguments available: that the physician was not practicing up to the required standard of care¹¹¹ or that he or she failed to obtain the patient's in-

100. Katz, *Bad Doctors: Who is Watching?*, Det. Free Press, Apr. 6, 1984, at 1A and 12A, cols. 1-6; Katz, *Bad Doctor: What Are the Answers?*, Det. Free Press, Apr. 8, 1984, at 1A, col. 3; Wolfe, Bergman & Silver, *supra* note 96, at 6.

101. Katz, *Staying a Step Ahead*, Det. Free Press, Apr. 4, 1984, at 1A, col. 4.

102. *Id.*

103. *Id.* J. GUINTEHER, *supra* note 37, at 145-46; Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV 51, 65 (1977); Det. Free Press, July 5, 1983, at 1A, col. 5. *See also infra* note 124 and accompanying text.

104. Katz, *Doctors Practice While Wheels Turn*, Det. Free Press, Apr. 1, 1984, at 1A, col. 1-5.

105. Katz, *Bad Doctors: A Second Chance*, Det. Free Press, Apr. 3, 1984, at 1A, col. 1 & 12A, col. 1; Katz, *Bad Doctors: Who Is Watching?*, *supra* note 100, at 12A, col. 1; Wolfe, Bergman & Silver, *supra* note 96, at 2-3.

106. K. FINEBERG, J. PETERS, J. WILLSON & D. KROLL, OBSTETRICS/GYNECOLOGY AND THE LAW 76-82 (1984) [hereinafter cited as OBSTETRICS/GYNECOLOGY AND THE LAW].

107. W. PROSSER & W. KEETON, LAW OF TORTS 39-40 (5th ed. 1984). *See, e.g.*, *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

108. W. PROSSER & W. KEETON, *supra* note 106, at 39-40.

109. *Id.* at 119.

110. *Id.* at 185-87.

111. *Id.* at 189.

formed consent.¹¹² Conceptually, the failure to obtain informed consent is a failure to live up to a standard of care that includes the notion of communicating treatment alternatives and their risks to patients—in theory, to permit them to exercise their own best judgment based on the information provided by the practitioner.¹¹³ Thus, a physician who either fails to practice up to the medical standard of care or who fails to provide adequate information to a patient may be successfully sued for injuries that are proved to be caused by such failure.¹¹⁴ Today battery is still available in cases where no consent was obtained¹¹⁵ and in some jurisdictions is still used on the basis that the patient's consent was not informed.¹¹⁶ The majority of jurisdictions, however, prefer the use of a negligence cause of action when informed consent is at issue.¹¹⁷

Both prongs of the plaintiff's negligence case provide direction to policymakers seeking solutions to the current obstetrical malpractice crisis. Considering first the standard of care, a review of judicial decisions reveals the hesitancy of judges to interfere with the judgments of a fellow profession.¹¹⁸ Courts generally have allowed the medical profession to establish standards it deems appropriate.¹¹⁹ During litigation, the proper standard of care must be proved through expert medical testimony.¹²⁰ This state of affairs created a severe handicap for some plaintiffs who were unable to find experts to testify on their behalf because of the application of the court-fashioned "locality rule."¹²¹

A. The Physician's Standard of Care

1. *The Current Locality and Specialist Rules*

In the early days of malpractice litigation, the locality rule was used in the determination of whether the quality of care provided by

112. *Id.* at 189-90.

113. *See, e.g.,* *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 418-422.

114. *See, e.g.,* *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 245-46, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 515 (1972).

115. OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 31-32.

116. W. PROSSER & W. KEETON, *supra* note 106, at 189-90.

117. *Id.*

118. *Id.* at 189. OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 23; J. KATZ, *supra* note 49, at 59.

119. W. PROSSER & W. KEETON, *supra* note 106, at 189.

120. *Id.* at 188.

121. *Id.*

defendant physicians was adequate.¹²² This meant that the plaintiff had to introduce expert testimony to establish the common practice of other physicians in good standing within the *same* community.¹²³ Better practices of physicians in nearby localities, which might have led to a better outcome for the patient, were irrelevant to the case.¹²⁴

Strict adherence to the locality rule created an insurmountable difficulty for many would-be plaintiffs. The now famous "conspiracy of silence" made it impossible in many cases for plaintiffs to obtain the necessary expert testimony.¹²⁵ Physicians refused to testify against their local colleagues even when they were convinced that malfeasance had occurred.¹²⁶ There were a number of reasons for their refusal, largely rooted in their fear of reprisal. Such reprisals might come in the form of the denial of hospital privileges, the elimination of patient referrals and the willingness to testify against the turncoat in future proceedings.¹²⁷

In the 1950s, '60s and '70s courts began to move away from a strict application of the locality rule. The first inroad came when courts expanded the rule to include physicians from "the same *or similar* locality."¹²⁸ Other courts moved to include physicians from "the same school."¹²⁹ Finally, for specialists, most courts expanded the territory of the rule to include the entire United States.¹³⁰ This expansion was based on the theory that the knowledge of specialists should be substantially equivalent because of uniform certification requirements for various specialties and continuing education requirements that force specialists to keep abreast of the latest developments in their fields.¹³¹

Under the modern rule for specialists, the plaintiff has little difficulty finding a willing medical expert witness. Across the country more and more courts have adopted this expanded view of the locality rule, based on the rationale stated above, in order to make it possible

122. *Id.*

123. *Id.* at 187-88. See also Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 410 (1969).

124. Waltz, *supra* note 122, at 410-11.

125. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 568, 317 P.2d 170, 175 (1957); *Huffman v. Lindquist*, 37 Cal. 2d 465, 477-78, 234 P.2d 34, 45-46 (1951); *Sampson v. Veenboer*, 252 Mich. 660, 667, 234 N.W. 170, 172 (1931); OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 164; Meisel, *supra* note 103.

126. J. GUINTELL, *supra* note 37, at 37-38.

127. *Id.* See also Det. Free Press, July 5, 1983, at 1A, col. 4 & 11A, col. 1.

128. Waltz, *supra* note 122, at 411-12 (emphasis added).

129. See, e.g., *Karp v. Cooley*, 349 F. Supp. 827, 836 (S.D. Tex. 1972); *Natanson v. Kline*, 186 Kan. 393, 411, 350 P.2d 1093, 1107 (1960).

130. OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 21-22. See, e.g., *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968); *Naccarato v. Grob*, 384 Mich. 248, 253, 180 N.W.2d 788, 790-91 (1970).

131. OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 22.

for plaintiffs to make a prima facie case.¹³² But the transformation of the locality rule also has additional ramifications. As a result of the territorial expansion of the locality rule for specialists, both physicians and patients have open to them a greater variety of medical techniques and practice styles. The specialist rule puts pressure on physicians to keep abreast of changes in their specialty, but at the same time permits them greater latitude in treatment options.

2. *A Proposed Solution—The Widest Possible Community*

An even more expansive view of the specialist rule or standard of care would benefit both doctor and patient. The adoption of the widest possible community within which acceptable standards could be found would accord the fullest array of alternatives and would provide the greatest measure of flexibility to both physicians and patients. A larger community is likely to have within it a greater number of approaches to a particular medical problem since it embodies a greater diversity of opinion as to appropriate treatment alternatives. At the same time, a larger community offers more protection to practitioners faced with malpractice claims based on alleged failure to observe the standard of care, since adherence to a respectable minority view in the relevant community is sufficient.¹³³

Based on the court decisions in this area over the last thirty years, it can be seen that change has occurred and that movement has been toward the recognition of a larger community for purposes of establishing the proper standard of care. Yet further expansion is needed if the twin goals of physician protection and greater diversity of alternatives in medical treatment are to be achieved. Further expansion of the relevant community to include all areas where western medicine is practiced would, in the case of obstetrics, bring in such innovative locations as the Netherlands, where home births are the norm and the rate of cesarean section is relatively low¹³⁴ and where infant mortality and morbidity rates are also low.¹³⁵

132. *Id.* at 21.

133. W. PROSSER & W. KEETON, *supra* note 106, at 187; OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 30.

134. In 1980, while 2 to 2.5% of U.S. births took place at home, the Netherlands' home birth rate was about 40%. D. STEWART, THE FIVE STANDARDS FOR SAFE CHILDBEARING 204, 223 (1981). The rate of cesarean deliveries in the Netherlands during that year was 5%. S. SAGOV, R. FEINBLOOM, P. SPINDEL & A. BRODSKEY, HOME BIRTH: A PRACTITIONER'S GUIDE TO BIRTH OUTSIDE THE HOSPITAL 26 (1984). That same year, the U.S. rate was 16.5% nationally, OBSTETRICAL INTERVENTION, *supra* note 23, at 183, and close to 25% at some U.S. institutions, H. MARIESKIND, *supra* note 6, at 1.

135. For example, 1977 perinatal death rates: U.S. 14.1/1000 births, Netherlands, 9.5/1000 births. Wegman, *Annual Survey of Vital Statistics*, 64 PEDIATRICS 835, 842, Dec. 1979.

3. *A Proposed Solution—Diminish Physician Control over Standard of Care*

Policymakers desiring to give a greater share of control to birthing women, while at the same time protecting physicians from suit, could take a greater hand in determining the standard of care. Policymakers should be encouraged by Justice Holmes' declaration (in a non-medical case) that "[w]hat usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not."¹³⁶ Justice Holmes and Judge Hand¹³⁷ recognized the problem inherent in allowing any group to establish its own standards: the standards may provide inadequate protection to those whom they are supposed to protect.¹³⁸

Realistically, judicial or legislative alteration of medical standards will happen slowly, if at all, given the deference that traditionally has been shown to the judgment of the medical community regarding the establishment of treatment standards.¹³⁹ This deference has not been the rule in other areas of endeavor, however, such as products liability.¹⁴⁰ Court scrutiny of manufacturing standards in products liability cases could serve as precedent for the action proposed here. Courts in product liability cases have been quick to hold that while industry practice is a relevant factor, judicial acceptance of those practices without scrutiny would be a dereliction of duty.¹⁴¹

The same argument should be made for medicine. It was successful in one case, *Helling v. Carey*.¹⁴² In that case the Washington Supreme Court, sitting *en banc*, was convinced that the physicians' failure to conduct a simple and inexpensive test that would have prevented the plaintiff's blindness presented a clear case of an inadequate standard of care set by the medical community.¹⁴³ On that basis the

136. *Texas & Pac. Ry. Co. v. Behymer*, 189 U.S. 468, 470 (1903) (citing *Wabash Ry. Co. v. McDaniels*, 107 U.S. 454 (1882)).

137. See *infra* note 144 and accompanying text.

138. See also *Lundahl v. Rockford Mem. Hosp. Ass'n*, 93 Ill. App. 2d 461, 235 N.E.2d 671 (Ill. App. Ct. 1968); *Favalora v. Aetna Casualty & Sur. Co.*, 144 So. 2d 544 (La. Ct. App. 1962); *Toth v. Community Hosp.*, 22 N.Y.2d 255, 239 N.E.2d 368 (1968); *Morgan v. Sheppard*, 91 Oh. L. Abs. 579, 188 N.E.2d 808 (Oh. Ct. App. 1963); *Incolingo v. Ewing*, 444 Pa. 263, 282 A.2d 206 (1971).

139. See *supra* notes 7-18 and accompanying text.

140. W. PROSSER & W. KEETON, *supra* note 106, at 194-95.

141. See, e.g., *Marietta v. Cliffs Ridge, Inc.*, 20 Mich. App. 449, 174 N.W.2d 164 (Mich. Ct. App. 1970); *Tite v. Omaha Coliseum Corp.*, 144 Neb. 22, 12 N.W.2d 90 (1943); *Shafer v. H.B. Thomas Co.*, 53 N.J. Super. 19, 146 A.2d 483 (App. Div. 1958); *Maize v. Atlantic Ref. Co.*, 352 Pa. 51, 41 A.2d 850 (1945); *Pan Am. Petroleum Corp. v. Like*, 381 P.2d 70 (Wyo. 1963).

142. 83 Wash. 2d 514, 519 P.2d 981 (1974). This case was reversed in 1975 by action of the Washington legislature. WASH. REV. CODE ANN. § 4.24.290 (Supp. 1986).

143. *Helling v. Carey*, 83 Wash. 2d 514, 518-19, 519 P.2d 981, 983 (1974).

court declared a new standard as a matter of law.¹⁴⁴

In 1932, Judge Learned Hand (in a non-medical case) stated that "a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required"¹⁴⁵ This power has been recognized in the medical setting as demonstrated by the *Helling* case;¹⁴⁶ courts have only to exercise it. As stated previously,¹⁴⁷ the standards adhered to by obstetricians today increasingly have come under attack as unwarranted, unsubstantiated and, in some cases, injurious.¹⁴⁸ Since the medical profession has not yet acted on this information, perhaps now is the time for legislatures and courts to do so by declaring an obstetrical standard of care that takes into account recent criticism and findings that call into question much of current obstetrical practice. At a minimum, the standard should reestablish the distinction between the at-risk patient—the six percent¹⁴⁹ for whom the use of obstetrical high technology may be outweighed by its benefits—and the low-risk majority.

B. Informed Consent

In addition, action should be taken to make the doctrine of informed consent a tool to protect physicians and, at the same time, to provide patients with access to the decisionmaking process. Although the roots of informed consent reach back to early battery and consent law, as an independent doctrine it is of relatively recent origin and is still emerging and evolving in legal thinking. Further change and refinement, along the lines suggested below, can and should be made to help in easing the medical malpractice crisis of the 1980s.

1. History of the Law

Informed consent sprang from the notion of consent. As discussed earlier,¹⁵⁰ medical treatment rendered without consent was (and still is) considered battery.¹⁵¹ In an early battery case, then-Judge Cardozo articulated the basis for the future doctrine of informed consent: "Every human being of adult years and sound mind has a right to de-

144. *Id.* at 519, 519 P.2d at 983.

145. The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).

146. *Helling v. Carey*, 83 Wash. 2d 514, 519, 519 P.2d 981, 983 (1974).

147. See *supra* notes 22-23 and accompanying text.

148. See *supra* note 23.

149. R. BRADLEY, *supra* note 64, at 196. The number of pregnancies placed in the high-risk category is considerably higher (10 to 30%) in Ott, *Routine Prenatal Care and Identification of the High-Risk Patient*, in HIGH-RISK PREGNANCY AND DELIVERY 10 (F. Arias ed. 1984).

150. See *supra* note 106 and accompanying text.

151. *Id.*

termine what shall be done with his own body. . . ."¹⁵² Supporters of informed consent state that the individual's right of self-determination is fundamental to American conceptions of free will and self-determination.¹⁵³

In the 1950s courts began to move toward adopting the notion that medical patients have the right to be informed in detail about diagnosis and treatment in order to permit them to share intelligently in medical decisionmaking. In 1957, the California Supreme Court approved this philosophy, stating that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."¹⁵⁴ In 1960, the Kansas case of *Natanson v. Kline*¹⁵⁵ sent shock waves through the medical community by declaring unambiguously the patient's right to make an informed consent¹⁵⁶ and the concomitant duty of the physician to provide sufficient information.¹⁵⁷ Physicians continued to be protected, however, by the standard against which the sufficiency of the provided information was to be measured. While declaring that patients had a right to information and to decide, the court in fact withheld these rights by holding that the sufficiency of the information provided would be measured against the standard of what a reasonable physician would have disclosed.¹⁵⁸

Physicians and their insurers were again stunned in 1972 by *Canterbury v. Spence*,¹⁵⁹ which established what they believed to be an even more troublesome standard. The new standard abandoned the

152. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). This idea has been quoted, paraphrased and expanded upon by courts and commentators discussing the issue of informed consent. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Sard v. Hardy*, 281 Md. 432, 439, 379 A.2d 1014, 1019 (1977); *Harnish v. Children's Hosp. Medical Center*, 387 Mass. 152, 155, 439 N.E.2d 240, 242 (1982); *Kessenick & Mankin, Medical Malpractice: The Right to Be Informed*, 8 U.S.F.L. REV. 261, 263 (1973); Comment, *Informed Consent: Patient's Right to Comprehend*, 27 HOW. L.J. 975, 976 (1984); Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172, 173 (1981) [hereinafter cited as *Patient Participation*].

153. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 364-76 (1974); Meisel, *supra* note 112, at 419-21; Note, *supra* note 71, at 242; *Patient Participation*, *supra* note 151, at 174-75.

154. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

155. 186 Kan. 393, 350 P.2d 1093 (1960).

156. *Id.* at 403-09, 350 P.2d at 1104-06.

157. *Id.* at 409, 350 P.2d at 1106.

158. *Id.*

159. 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). See also *Cobbs v. Grant*, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (decided by the California Supreme Court and relied upon by the *Canterbury* court in its opinion).

reasonable physician or "professional" standard declared in *Natanson*¹⁶⁰ and in its place created a subjective, patient-oriented test.¹⁶¹

Nonetheless, the patient's full right of self-determination still remained out of reach. The court ruled that causation must be established with reference to whether the reasonably prudent patient in the plaintiff's position would have gone forward with treatment,¹⁶² not whether the plaintiff would have done so.¹⁶³ One court took that additional step, and applied a subjective standard to the issue of causation. In *Scott v. Bradford*,¹⁶⁴ the Oklahoma Supreme Court expressed confidence that, in making its usual determinations of credibility, the jury is capable of weighing the veracity of the plaintiff's biased hindsight statements.¹⁶⁵ The majority of courts, however, maintain the *Natanson* position,¹⁶⁶ based on a professional standard, and most legislatures that have acted have also adopted a restrictive approach.¹⁶⁷

Informed consent and the right to self-determination remain undermined in an American legal system that declares the existence of these rights and then subverts them. These rights are subverted by holdings which declare that patients have only the right to be told what is going to happen to them before they consent and not the right to choose from an array of options (when such options exist) with the advice of and in consultation with the physician. As a result, due to the current interpretation, the patient's right of self-determination is a meager one indeed. It is subject to physician control through court-developed tests (discussed above) and exceptions based primarily on deference to medical community judgments (discussed below).

Many commentators who advocate informed consent because of a belief in the right of self-determination and the benefit of preserving

160. *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

161. *Id.* at 785. The court stated that "[i]n our view, the patient's right of self-decision shapes the boundaries of the duty to reveal The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision." *Id.* at 786.

162. *Id.* at 790-91.

163. *Id.* See also Meisel, *supra* note 103, at 112.

164. 606 P.2d 554 (Okla. 1979).

165. *Id.* at 558-59. For discussions supporting this position, see Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 162-63 (1977), and Meisel, *supra* note 103, at 112.

166. A. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 35-36 (1981); Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163, 176 (1984); Note, *Medical Malpractice: A Subjective Approach to Informed Consent in Oklahoma*, 15 TULSA L.J. 665, 660 (1980); Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal*, 12 PAC. L.J. 915, 918 (1981).

167. J. KATZ, *supra* note 49, at 81-82; Andrews, *supra* note 165, at 179; Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 423-24 (1980).

human dignity are willing, in the medical context, to accept significant intrusions on this right in the name of health.¹⁶⁸ Presumably the good health of the individual, because of its importance to society as a whole (increased productivity, lower health care costs), justifies the creation of the judicially formulated exceptions¹⁶⁹ to the requirement of informed consent.¹⁷⁰

a. Exceptions to the Rule

Based on the general notion that good health benefits society, four exceptions to the requirement of informed consent have been carved out: waiver, therapeutic privilege, emergency and incompetency.¹⁷¹ The first exception, waiver, in a sense retains the self-determination concept.¹⁷² The patient may simply delegate his or her power to decide to the physician by stating that he or she chooses not to be informed and to rely completely on the physician's judgment.¹⁷³

The other three exceptions give outright decisionmaking authority to the physician. Under the therapeutic privilege exception, a physician may decide that the provision of information is not in the best interests of the patient.¹⁷⁴ Under these circumstances, in the eyes of the law, the physician is justified in withholding diagnosis or proposed treatment information.¹⁷⁵

There is discord on the validity of this exception. Some commentators argue that the privilege expresses an unacceptable paternalism and, as a matter of theory, should be greatly narrowed if not eliminated.¹⁷⁶ Others point out that it creates an exception capable of swallowing the rule because physicians, fearful that a patient will make

168. See, e.g., *Natanson v. Kline*, 186 Kan. 393, 403, 350 P.2d 1093, 1104 (1960); *Harnish v. Children's Hosp. Medical Center*, 387 Mass. 152, 158, 439 N.E.2d 240, 244 (1982); Meisel, *supra* note 112, at 430; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 641-43 (1970); *Patient Participation*, *supra* note 151, at 176-77.

169. A number of states have placed these exceptions in statutes. See Andrews, *supra* note 165, at 202-16.

170. See, e.g., Meisel, *supra* note 112, at 423-25.

171. These are the principal exceptions, but others have been made in some cases. For example, the physician need not disclose a risk of which the patient is already aware. See OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 36. In *Holt v. Nelson*, 11 Wash. App. 230, 240-42, 523 P.2d 211, 218-19 (1974), the court identified nine exceptions.

172. Meisel, *supra* note 112, at 453-60.

173. *Id.*

174. *Id.* at 460-70.

175. *Id.* at 460.

176. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Note, *Informed Consent: The Illusion of Patient Choice*, 23 EMORY L.J. 503 (1974); *Patient Participation*, *supra* note 151, at 177-78.

the "wrong" decision and refuse treatment, will claim the privilege.¹⁷⁷ Still other critics contend that it is counterproductive.¹⁷⁸ They call attention to studies that they believe prove that the provision of complete information to patients is highly beneficial because it prepares them for what may happen as a result of treatment.¹⁷⁹ Under this theory, the patient begins, in advance, the process of accepting possible treatment results instead of being shocked by an outcome about which the patient was not forewarned. An unexpected outcome is likely to deal a severe blow to both mind and body¹⁸⁰ and result in a malpractice suit.¹⁸¹

The remaining exceptions to the informed consent doctrine have drawn less fire. Courts have uniformly supported physician treatment without consent in emergency situations, when time is too short for discussion.¹⁸² A related exception covers circumstances in which the patient is not competent to make decisions.¹⁸³ Again, in these cases the societal value of good health prevails in instances when the individual is incapable of self-determination.

b. Physicians' View of the Rule

A number of criticisms have been leveled against the existing doctrine of informed consent or its expansion. Physicians insist that it is a burdensome requirement that takes valuable time away from treating other patients.¹⁸⁴ Given the poor state of the relationship that many physicians have with their patients, and the impact of this fact on the current level of malpractice litigation,¹⁸⁵ the legal requirement of informed consent should be considered in a more positive light. It might present an opportunity for beneficial change that could lead to a reduction in malpractice suits. Providing detailed information to patients through thorough give-and-take discussions in which dialogue is genuinely encouraged, could help to establish and build a personal and

177. Meisel, *supra* note 103, at 100-01; MAKING HEALTH CARE DECISIONS, *supra* note 61, at 95.

178. Annas, *supra* note 71, at 17; *Patient Participation*, *supra* note 151, at 178-79.

179. Annas, *supra* note 71, at 12. Baudry & Wiener, *Preoperative Preparation of the Surgical Patient*, 63 SURGERY 885, 885-89 (1968); Rockwell & Pepitone-Rockwell, *The Emotional Impact of Surgery and the Value of Informed Consent*, 63 MED. CLINICS N. AM. 1341, 1342 (1979).

180. Rockwell & Petitone-Rockwell, *supra* note 178, at 1342. See also Annas, *supra* note 71, at 12.

181. Annas, *supra* note 71, at 12; Morrow, *supra* note 45, at 576-77.

182. Meisel, *supra* note 112, at 443-38.

183. *Id.* at 439-53.

184. A. ROSOFF, *supra* note 165, at 319; Meisel, *supra* note 112, at 439-53; Trichter, *Informed Consent: The Patient as an Individual*, 15 FORUM 455, 463 (1980); MAKING HEALTH CARE DECISIONS, *supra* note 61, at 104; Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal*, 12 PAC. L.J. 915, 929 (1981).

185. See *supra* notes 71-75 and accompanying text.

trusting relationship. Several law review articles offer good suggestions on the mechanics of communicating the required information.¹⁸⁶

Physicians have also expressed deep concern about what they perceive as a lack of specificity regarding the content and scope of information that must be provided. A number of commentators have agreed with them.¹⁸⁷ For example, court opinions addressing the issue talk in terms of "reasonable disclosure of choices,"¹⁸⁸ "material information,"¹⁸⁹ "material risks,"¹⁹⁰ and "reasonable familiarity with the therapeutic alternatives."¹⁹¹ This seeming lack of clarity may present difficulties for the health care provider looking for a checklist solution in order to cover all required points of information in the least possible time. It should be less troublesome when provider and patient enter into an informed consent dialogue. Even the courts most strongly favoring informed consent have been careful to say that the physician need not discuss remote possibilities¹⁹² unless, of course, the patient requests that information. During informed consent discussions the physician should be able to determine what information is important to the patient and provide it. A patient who has a rudimentary understanding of the diagnosis and the treatment alternatives, who has confidence in the physician, and who, with the physician's advice, has personally weighed the available alternatives, is far less likely to sue later.¹⁹³

Another obstacle in the path of *truly* informed patient consent is the widely held belief that most patients are incapable of grasping either the diagnosis or treatment alternatives.¹⁹⁴ If we assume this to

186. See, e.g., Andrews, *supra* note 165, at 182-204; Trichter, *supra* note 183, at 463; *Patient Participation*, *supra* note 151, at 190-206. See also A. ROSOFF, *supra* note 165, at 113-28.

187. Plant, *The Decline of "Informed Consent"*, 35 WASH. & LEE L. REV. 91, 99-100 (1978); Note, *Malpractice: Towards a Viable Disclosure Standard for Informed Consent*, 32 OKLA. L. REV. 868, 869 (1979); *Patient Participation*, *supra* note 151, at 174-75. See also A. ROSOFF, *supra* note 165, at 52.

188. *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

189. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

190. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

191. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

192. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 244, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

193. Annas, *supra* note 71, at 11; Morrow, *supra* note 45, at 557; Trichter, *supra* note 183, at 463-64; Note, *supra* note 186, at 884.

194. Katz, *supra* note 164, at 148; McKinlay, *Who Is Really Ignorant—Physician or Patient?*, 16 J. HEALTH & SOC. BEHAV. 3 (1975).

be true, we may legitimately be concerned about decisions based on misconstrued or misunderstood information. Although consistent with the right of self-determination, misinformed decisions are likely to be of poor quality and, consequently, against the best interests of society which opts for maximization of individual health, other things being equal.

Studies have shown this skepticism to be misplaced.¹⁹⁵ While this issue has not been fully researched, those studies that have investigated patient understanding of explanations of fairly complex medical procedures generally have found good comprehension.¹⁹⁶ Furthermore, through these studies researchers have identified ways in which providers may better present information to best assure its comprehension.¹⁹⁷ Heartened by these study results, physicians should now feel that such explanations are an effective use of their time because, again, the fully informed patient decisionmaker is less likely to sue.¹⁹⁸

2. *Informed Consent in Obstetrics*

Informed consent is a factor in all kinds of medical treatment, but it is of particular importance in the area of pregnancy and childbirth. As discussed earlier, more and more women are rejecting the current obstetrical standard of care and are demanding the right to make their own decisions regarding their pregnancies and births.¹⁹⁹ Increasingly, women see childbirth as a intensely personal experience over which they want control. They are willing to devote substantial amounts of time to researching the process and the standard medical procedures used by obstetricians in order to make intelligent decisions.²⁰⁰

Clearly, this is a departure from days not too far gone by when women simply submitted to whatever their physicians proposed.²⁰¹ This change has created tremendous friction between some pregnant women and the physician community. Physicians are highly resistant to giving up control of decisionmaking.²⁰² Providing them with a strong defense to claims of negligence in cases in which the pregnant or birthing woman has opted to make her own choices would in part resolve this tension and further the self-determination goal of the informed consent doctrine.

195. For a discussion of the studies that have been undertaken, see Meisel & Roth, *Toward An Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 263, 293 (1983).

196. *Id.* See also Andrews, *supra* note 165, at 180-204.

197. Epstein & Lasagna, *Obtaining Informed Consent: Form or Substance*, 123 ARCHIVES INTERNAL MED. 682 (1969).

198. See *supra* note 192 and accompanying text.

199. See *supra* note 48 and accompanying text.

200. Y. BRACKBILL, J. RICE & D. YOUNG, *supra* note 16, at 75.

201. B. KATZ ROTHMAN, *supra* note 22, at 29-30; Morrow, *supra* note 45, at 557-63.

202. See *supra* note 48 and accompanying text.

3. *Greater Assumption of Risk*

To achieve this objective, it is proposed that courts and legislatures adopt rules that give substantial control over practices and procedures that might be used during pregnancy and childbirth to those women who wish to exercise that control. In exchange for the woman's right to decide, the physician must be given protection from claims of failure to meet the standard of care so long as it is proved that the woman's choice and alternatives to it were fully discussed. In other words, the pregnant woman must accept responsibility for her decisions. Within this proposed framework, she should be found to have assumed the risk, precluding liability for the physician in the absence of negligent care.²⁰³

This proposition may be problematic because existing case law has drawn a distinction between the assumption of medical and non-medical risks.²⁰⁴ A patient may assume non-medical risks (getting out of a hospital bed resulting in an injury, for example), but generally courts have not allowed this defense in cases involving medical risks.²⁰⁵ In the latter case, it is believed that the patient cannot assume a risk that he or she cannot understand due to the great complexity of medical science.²⁰⁶ Therefore, the patient has the right to rely totally on the physician's medical expertise and to be protected from his or her own decisions.²⁰⁷ As a consequence, in almost all jurisdictions, the assumption of risk defense is unavailable to physicians who have shared decisionmaking with patients only to be sued later.²⁰⁸ In order to give birthing women authority in the childbirth process, courts and legislatures must adopt a uniform rule for both medical and non-medical risks. The assumption of the risk defense should be made available to physicians to effectuate the right of the patient to make decisions and to impose on the patient the concomitant duty to accept responsibility for those decisions.

203. This idea has received support primarily in legal scholarship. *See, e.g.*, Meisel, *supra* note 103, at 128-29; Note, *supra* note 71, at 255-56. Thus far it has been adopted by few courts. *See* *Routt v. Ready*, 265 F. 455 (D.C. Cir. 1920); *Steele v. Woods*, 327 S.W.2d 187 (Mo. 1959); *Mainfort v. Giannestras*, 49 Ohio Op. 490, 111 N.E.2d 692 (Ohio Ct. App. 1951).

204. OBSTETRICS/GYNECOLOGY AND THE LAW, *supra* note 105, at 147.

205. *Id.*

206. *Id.* at 148.

207. *Id.*

208. *Id.* at 147. *But see* *Mainfort v. Giannestra*, 49 Ohio Op. 490, 111 N.E.2d 692 (Ohio Ct. App. 1951) (physician who carefully and fully explained the risk due to patient's diabetic condition successfully asserted this defense). *See also* *Routt v. Ready*, 265 F. 455, 456 (D.C. Cir. 1920); *Steele v. Woods*, 327 S.W.2d 187, 196 (Mo. 1959).

4. *Right to Refuse Treatment*

a. *The General Rule*

The patient's right to make decisions regarding medical treatment has been given additional support through the existing right to refuse treatment, certainly a necessary corollary of informed consent. If it is to mean anything at all, the requirement of consent must, by implication at least, include the right to refuse to give consent.

A decision to refuse treatment clearly carries with it potentially hazardous results. It should be noted, however, that in the name of individual liberty, our society condones a variety of hazardous activities such as smoking tobacco, drinking alcohol, laboring in construction of buildings and bridges of enormous height, and mining minerals underground. All of these activities involve great personal risks and relatively little government interference. In the medical setting, in contrast, there has been a greater effort to regulate action viewed as hazardous to health; namely, refusing treatment advised by a physician. Yet in the cases in which this issue has been presented, courts generally have upheld the right of the individual to decide against treatment despite the pleas of physicians and hospitals.²⁰⁹

The great majority of the older cases involved persons whose religious convictions precluded treatment.²¹⁰ More recently, because of new life-sustaining technologies, courts have been asked to turn their attention to whether the individual (or the individual's family) has a right to refuse treatment that prolongs life in a clearly terminal case.²¹¹ By and large, courts have found the individual's rights of self-determination compelling,²¹² save in circumstances where they would leave helpless dependents in the event of their demise.²¹³ Thus, parents on whose income children depend to survive were denied the right to refuse blood transfusions.²¹⁴ Where a parent made adequate financial provision for dependents, however, the court declined to order a transfusion and upheld his right of self-determination.²¹⁵

b. *Refusal of Treatment in Obstetrics*

A different case presents itself in the obstetrical setting where the rights of more than one individual may be directly involved. In addition to the right of the individual to determine what will or will not

209. Annot., 93 A.L.R.3d 67 (1979); Annot., 9 A.L.R.3d 1391 (1966).

210. Annot., 9 A.L.R.3d 1391, 1393 (1966).

211. Annot., 79 A.L.R.3d 237 (1977).

212. See *supra* note 208 and accompanying text.

213. Annot., 9 A.L.R.3d 1391, 1393-94 (1966).

214. See, e.g., *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 337 U.S. 978 (1964).

215. *In re Osborne*, 294 A.2d 372 (D.C. 1972).

happen to her body, consideration must be given to whether the fetus has rights deserving protection. The rights of the fetus may impinge upon the woman's right and may limit her ability to refuse treatment.

Court decisions involving pregnant women where the life of the fetus is believed at risk have established such limitations. Since by its very nature a fetus needs its mother's living body to survive, one court ordered a blood transfusion for a pregnant woman.²¹⁶ Another court, convinced that the woman's refusal of treatment would likely result in the death of the fetus, ordered her to submit to a cesarean section delivery.²¹⁷ In those cases, the courts had to weigh the seemingly conflicting and yet inextricably intertwined interests of two individuals. The societal value of preservation of life, when joined with the interests of the fetus in at least the potential for life, were held to outweigh the woman's right of self-determination.²¹⁸ As a result, it is probably unrealistic for advocates of the woman's right of self-determination to expect courts to support a woman's decision in cases of this kind until, through further technological change, the fetus is capable of surviving outside the mother's body.

Courts should favor a more narrowly drawn right in circumstances where fetal life is not at risk. A review of the relevant case law revealed no cases where the court intervened to order treatment for a pregnant woman in a situation not viewed as imminently life-threatening to the fetus. In the future, court decisions regarding fetal rights might present a serious impediment to a pregnant woman's right of informed consent. At this juncture, however, it appears that courts likely will respect the mother's judgment regarding the management of her pregnancy, barring a situation which threatens the life of a presumed normal fetus. As these issues are presented in the future, courts have strong precedent in the right-to-withdraw treatment and defective newborn cases²¹⁹ on which to rely to protect the medical decisionmaking rights of the pregnant woman.

In this regard, a review of the court resolutions of related issues such as abortion and the rights of parents vis-a-vis a seriously defective newborn is useful. The decisions in cases such as *In re Quinlan*²²⁰ and the *Baby Doe* cases²²¹ seem to favor parental rights and, by anal-

216. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964).

217. *Jefferson v. Griffin Spaulding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

218. See *supra* cases cited at notes 215-16.

219. See *infra* notes 219-20 and accompanying text.

220. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

221. *In re Infant Doe*, No. GU8204-004A (Ind. Cir. Ct. Monroe County, Apr. 10, 1982) (declaratory judgment). Because the records in this case were sealed by the Indiana Supreme Court, the author relies upon interviews of the interested parties reported in J. LYONS, *PLAYING GOD IN THE NURSERY* 30-33 (1985). See *Weber v.*

ogy, offer support to pregnant and birthing women seeking self-determination. In these cases, parents received court approval of their decisions to withdraw treatment²²² and to withhold treatment in what they viewed as hopeless situations.²²³

Absent a finding of abuse on the part of parents, many courts that considered these issues held that it was safe to assume parental decisions were in the children's best interests, particularly when supported by medical opinion.²²⁴ The right to privacy was also raised in some of these court decisions. Generally courts have not found this principle by itself to support the parents' right to decide.²²⁵

At the federal level, parental decisionmaking power has not been restricted. The U.S. Supreme Court tread cautiously in this area in the 1973 *Roe v. Wade* decision which found that, based on the right to privacy, women have a right to seek an abortion.²²⁶ Indeed, an attempt by the Reagan administration to usurp family decisionmaking with the promulgation of the "Baby Doe Rules" has met with failure.²²⁷ Once a step down that road is taken, it is hard to imagine where the line could be drawn. Shall pregnant women be subject to criminal sanctions for smoking tobacco or drinking alcohol or working in physically hazardous or high stress jobs? Thus far, the majority of courts have wisely chosen to place their faith in parental judgment and to support the integrity and privacy of the family.

c. *One More Step to Patient Self-Determination*

Taking the existing right of informed consent and the right to re-

Stony Brook Hosp., 95 A.D.2d 587, 467 N.Y.S.2d 685 (App. Div. 1983), *aff'd*, *Weber v. Stony Brook Hosp.*, 60 N.Y.2d 208, 456 N.E.2d 1186, 469 N.Y.S.2d 63 (1983).

222. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). *See also* Annot., 79 A.L.R.3d 237 (1977).

223. *See supra* note 220.

224. *See, e.g.*, *United States v. University Hosp.*, 575 F. Supp. 607, 614-15 (E.D.N.Y. 1983).

225. *See, e.g., id.* at 615-16. *But see In re Quinlan*, 70 N.J. 10, 38-41, 355 A.2d 647, 663-64 (1976) (privacy interest begins to outweigh state interest in preservation of life only as the degree of bodily invasion increases and hope for recovery dims); *Weber v. Stony Brook Hosp.*, 60 N.Y.2d 208, 213, 456 N.E.2d 1186, 1188, 469 N.Y.S.2d 63, 65 (1983) (circumstances may arise where the courts will be obligated to intervene to challenge the private decision of a family in order to protect a child).

226. *Roe v. Wade*, 410 U.S. 113 (1973).

227. The Reagan administration sought to force treatment of defective newborns through the promulgation of administrative rules. The interim final rules were struck down as arbitrary and capricious agency action. *American Academy of Pediatrics v. Heckler*, 561 F. Supp. 395 (D.D.C. 1983). The revised and final regulations were also struck down as being beyond the scope of the agency's statutorily granted authority. *American Hosp. Ass'n v. Heckler*, 585 F. Supp. 541 (S.D.N.Y. 1984), *aff'd sub nom. United States v. University Hosp.*, 729 F.2d 144 (2d Cir. 1984), *aff'd sub nom. Bowen v. American Hosp. Ass'n*, 106 S. Ct. 2101 (1986).

fuse treatment together, it can be seen that policymakers have moved toward allowing a full-blown right of self-determination in the medical treatment arena. A patient has the right to be provided information about the diagnosis and alternative treatments and their potential outcomes²²⁸ and usually has the right to refuse any of the alternatives presented.²²⁹ With only one more step, patients could be permitted to take an active role in treatment selection, to enter into discussions regarding the alternatives presented by the attending physician and to get the physician's opinion regarding other alternatives which may not have been presented to the patient.

For example, a pregnant woman whose labor is prolonged might decide to walk the hospital corridors or grounds for an hour to stimulate labor in lieu of the injection of a labor inducing hormone. Or a patient with arteriosclerosis (clogged arteries) who has received information about the risks of corrective surgery might decide to pursue a conservative dietary treatment that requires self-discipline and a longer period of time to achieve the desired results, but which entails considerably less risk of immediate serious injury or death. These patient choices would be possible, and the physician would be protected in the event that they lead to a poor outcome, only if the patient is fully informed and works with the physician to select a treatment plan.

The courts and legislatures already have taken a similar step in the realm of consumer rights, and an analogy can be drawn between choices of consumers of goods and services and consumers of health care services. As noted earlier,²³⁰ the last thirty years have brought a great burgeoning of consumer rights in the form of case precedents²³¹ and statutes.²³² Many of the rules in this area are designed to provide consumers with sufficient information to enable them to make the choices that are in their best interests as gauged by the consumers themselves.²³³

The policies behind consumer rights should be expanded to include the rights of health care consumers. To do so, the paternalism of the present health care delivery system must be rejected and medical pa-

228. See *supra* notes 149-99 and accompanying text.

229. See *supra* notes 208-24 and accompanying text.

230. See *supra* notes 83-89 and accompanying text.

231. See *supra* notes 84-85.

232. See *supra* notes 86-89.

233. For example, the Truth in Lending Act requires that all lenders quote interest rates in the form of an annual percentage rate so that consumers may comparison shop for credit. 15 U.S.C. § 1631 (1982). Also, many provisions of the Michigan Consumer Protection Act seek to eliminate false and misleading information about goods and services so that consumers may make judgments based on accurate information. MICH. COMP. LAWS ANN. § 445.903(a)-(t), (w), (y), (bb), (cc) (Supp. 1985).

tients given the right to make treatment decisions. If adequate information has been made available, the individual, whether buying an automobile or considering a tubal ligation, is surely in the best position to understand the ramifications of the various alternatives. Even though physicians normally have much more knowledge about the medical implications of treatment alternatives, only the affected individuals can fully appreciate the impact that potential choices may have on their lives.²³⁴ Admittedly, the complexities may be great when dealing with medical problems. Still, these complexities should not be permitted to justify the exclusion of the affected individual from the decisionmaking process, if the goal is in fact the promotion of self-determination and the protection of human dignity through informed consent.²³⁵ Furthermore, patient self-determination should lead to better medical outcomes²³⁶ and lower levels of malpractice litigation.²³⁷

IV. CONCLUSION

Fearful of malpractice suits, physicians find their practices limited by an increasingly restrictive, unproven standard of care that greatly increases medical care costs. Policymakers tackling this multifaceted problem should consider widening the geographical and hence the theoretical area of the standard of care. This widening will benefit patients and physicians by adding to the variety of alternative treatments. In addition, physicians will have greater legal protection under a broader standard. Review and alteration of unsubstantiated doctor-established standards of care also could benefit obstetrical patients by protecting them from unproven and unnecessary procedures. Moreover, it would also reduce pressure on physicians to intervene in the childbirth process and would lower health care costs.

Wishing to regain control of the birth place, today more and more women demand the right to a medically *assisted* birth and shared decisionmaking instead of the current standard of medically *managed* birth. In exchange for the right to make decisions about medical care, women must be willing to accept responsibility for those decisions. Physicians who relinquish or share decisionmaking authority with pregnant (or, for that matter, any other) patients must be protected by the assumption of the risk defense from claims alleging either failure to provide full information or failure to follow a standard of care from which the patient specifically requested that the physician deviate.

234. A. HOLDER, MEDICAL MALPRACTICE LAW 226 (2d ed. 1978); Morrow, *supra* note 45, at 576.

235. See *supra* notes 150-52 and accompanying text.

236. Andrews, *supra* note 165, at 165-68; *Patient Participation*, *supra* note 151, at 178-82.

237. See *supra* note 192 and accompanying text.

Patients who know and trust their physician, who share in decision-making and who know the possible results that lie ahead, are less likely to sue when a competent medical effort has been made even though the medical outcome is less than perfect.